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Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 431, 433, et al.
State Child Health; Revisions to the Regulations Implementing the State Children's Health Insurance Program; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 431, 433, 435, 436, and 457

[HCFA–2006–IFC]

RIN 0938–AL00

State Child Health; Revisions to the Regulations Implementing the State Children's Health Insurance Program

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period; revisions, delay of effective date, and technical amendments to final rule.

SUMMARY: Title XXI authorizes the State Children's Health Insurance Program (SCHIP) to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. On January 11, 2001 we published a final rule in the **Federal Register** to implement SCHIP that has not gone into effect. This interim final rule further delays the effective date, revises certain provisions and solicits public comment, and makes technical corrections and clarifications to the January 2001 final rule based on further review of the comments received and applicable law. Only the provisions set forth in this document have changed. All other provisions set forth in the January 2001 final rule will be implemented without change.

DATES: *Effective Date:* The effective date of the January 2001 rule (66 FR 2490), delayed on February 26, 2001 (66 FR 11547) and on June 11, 2001 (66 FR 31178) until June 25, 2001, is delayed for an additional 60 days, and will be effective, as amended by this rule, on August 24, 2001.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on July 25, 2001.

Compliance dates: To the extent contract changes are necessary, States will not be found out of compliance until the next contract cycle. By ''contract cycles'', we mean the earlier of the date of the original period of the existing contract, or the date of any extension or modification that would change the term of the contract. To the extent legislative changes are necessary, States will not be found out of compliance until the conclusion of the next legislative cycle following the effective date of the rule.

ADDRESSES: In commenting, please refer to file code HCFA–2006–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Mail written comments (one original and three copies) to the following address only: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–2006–IFC, P.O. Box 8016, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Regina Fletcher, (410) 786–3293;

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Terese Klitenic for subpart J, Allowable waivers, (410) 786–5942; and

Christina Moylan for subpart K, Applicant and enrollee protections (410) 786–6102.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Health Care Financing Administration, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call telephone number: (410) 786–7195.

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I. Background

Section 490l of the BBA, Public Law 105–33, as amended by Public Law 105–100, added title XXI to the Act. Title XXI authorizes the State Children's Health Insurance Program (SCHIP) to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through (1) a separate child health program that meets the requirements specified under section 2103 of the Act; (2) expanding eligibility for benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of the two approaches. To be eligible for funds under this program, States must submit a State child health plan (State plan), which must be approved by the Secretary.

SCHIP is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years (FY) 1998 through 2007. Federal payments under title XXI to States are based on State expenditures under approved plans effective on or after October 1, 1997.

On January 11, 2001, we published a final rule to implement SCHIP, which has not gone into effect (66 FR 2490). That final rule contained provisions regarding State plan requirements and plan administration, coverage and benefits, eligibility and enrollment, enrollee financial responsibility,

strategic planning, substitution of coverage, program integrity, waivers, and applicant and enrollee protections. The January 2001 final rule also included provisions to expand State options for coverage of children under the Medicaid program. On February 26, 2001, we delayed the effective date of the January 11, 2001 final rule for 60 days (66 FR 11547). On June 11, 2001, we delayed the effective date an additional 14 days, until June 25, 2001. We are further delaying the effective date of the January 11, 2001 final rule so that those provisions which were not revised by this interim final rule, as well as those which have been revised by this interim final rule (which are discussed in detail below), will all become effective on August 24, 2001.

After further Departmental review of the January 2001 final rule, and additional consideration of the public comments received on the November 8, 1999 proposed rule (64 FR 60882), we have decided to make revisions to certain provisions set forth in the January 2001 final rule. We note that only the provisions specified in this document have changed. All other provisions set forth in the January 2001 final rule will be implemented without change.

We note that we previously obtained public comments on the issues set forth in this document. We welcome parties to submit further comments on the issues presented in this interim final rule with comment period. To the extent that it is necessary to address any new concerns that are raised, we will do so.

II. Summary of Changes to the January 11, 2001 Final Rule

We received 109 timely comments on the November 8, 1999 proposed rule, which we responded to in the January 2001 final rule. As stated above, after further review of the public comments we are revising our responses to some of the comments set forth in the January 2001 final rule and revising the corresponding regulatory text. In addition, in this interim final rule, we are making certain technical changes to correct errors in the January 2001 final rule. In the following discussion we summarize the relevant public comments and present our revised responses.

A. State Plan Requirements: Eligibility, Screening, and Enrollment

1. Eligibility Standards (§ 457.320)

In the January 2001 final rule, § 457.320(b)(4) provided that a State may not require that any individual provide a social security number (SSN), including the SSN of the applicant child or that of a family member whose income or resources might be used in making the child's eligibility determination.

Comment: We received a large number of comments related to obtaining social security numbers (SSNs) during the application process. Many commenters specifically supported the prohibition against requiring the SSN in separate child health programs, while others recommended that SSNs be required for applicants as long as there is a Medicaid screen and enroll requirement. Some commenters indicated that the prohibition against requiring SSNs for a separate child health program while requiring it for Medicaid will cause referral, tracking and coordination problems; handicap enrollment in States using a joint application; make it difficult to implement the screen and enroll provision; reinforce stereotypes; and prevent automatic income verification in States that have reduced the documentation requirements. Another added that this prohibition would impede efforts to identify children with access to State health benefits. (66 FR 2541)

Response: We previously responded that the requirements and prohibitions related to the use of a social security number were statutory, based upon our interpretation of language in the Privacy Act. The Privacy Act makes it unlawful for States to deny benefits to an individual based upon that individual's failure to disclose his or her social security number, unless such disclosure is required by Federal law or was part of a Federal, State or local system of records in operation before January 1, 1975. Additionally, we responded that section 1137(a)(1) of the Act requires States to condition eligibility for specific benefit programs, including Medicaid, upon an applicant (and only the applicant) furnishing his or her SSN. Because SCHIP was not one of the programs identified in section 1137 of the Act, and title XXI does not require applicants to disclose their SSNs, we concluded that States were prohibited under the Privacy Act from requiring applicants to do so.

In our previous response, however, we did not discuss subsequent revisions to the Privacy Act that provided exceptions for ''general public assistance programs'' because we had interpreted that language to refer to only State-only welfare programs. Further investigation of the conference reports discussing the modifications made by Congress to the Privacy Act, namely the exceptions for ''general public assistance programs,'' revealed that Congress had a broader intent than referring to State-only welfare programs. We now interpret that term in a broader sense, and we believe SCHIP is a program that qualifies as an exception under the Privacy Act. We have been aware through our dialogue with the States that this provision inhibited the screen and enroll process, verification of private insurance, payment of premium assistance to an employee, and the evaluation capabilities for many States. The requirement also created significant administrative difficulties for those States that use joint applications with Medicaid.

Therefore, we are revising the final regulation to provide States with the option to require a SSN of applicants for SCHIP. However, similar to the requirements for Medicaid, only the SSN of the individual who is applying for benefits can be required as a condition of eligibility. States may not require other individuals not applying for coverage, including parents or other family members, to provide SSNs as a condition of the child's eligibility for either a Medicaid expansion program or a separate child health program. Section 457.320(b)(4) has been revised accordingly. We specifically solicit comments on the impact that this provision may have on immigrant populations.

Because we are now permitting States to require a social security number for each individual who is requesting services, we have also added a new provision at § 457.340(b) to assure necessary protections for use of a social security number consistent with the requirements currently set forth in the Medicaid regulations at § 435.910. This provision requires States to disclose the purpose for obtaining the social security number and to assist the applicant in obtaining or verifying an existing social security number. Section 435.910 also prohibits the State from denying or delaying services to an otherwise eligible individual pending issuance or verification of the individual's social security number. This provision makes the procedures and protections for a separate child health program consistent with procedures and protections under Medicaid. Consistency between the programs will facilitate the application process, particularly in States that use a joint application. We also note that in accordance with § 457.1110(b) of the January 2001 final rule, States are required to comply with regulations set forth at subpart F of part 431. These requirements specify that the State must provide safeguards that restrict the use or disclosure of information concerning

applicants and recipients to purposes directly connected with administration of the plan.

2. Eligibility Screening and Facilitation of Medicaid Enrollment (§ 457.350)

Paragraphs (e) and (g) of § 457.350 of the January 2001 final rule required States to provide SCHIP applicants with written information on the Medicaid program, but did not indicate the degree of flexibility as to the format and timing of that information.

Comment: Several commenters expressed their concern about the requirements that certain information about Medicaid should be provided to families if a State uses a screening procedure other than a full determination of Medicaid eligibility (66 FR 2547). Commenters indicated that they were concerned that this information could be confusing to families whose children were found eligible for a separate child health program. Commenters were also concerned that providing this information would slow down the eligibility determination process.

Response: We previously responded by providing clarifying language in § 457.350(e) and (g) regarding a State's responsibility to facilitate enrollment in Medicaid and to assist families in making informed application decisions. In these sections, we clarified that States must inform the family, in writing, that based on a limited review, the child does not appear to be eligible for Medicaid. We also required that a State provide certain information about the State's Medicaid program to enable a family to make an informed decision about applying for Medicaid or completing the Medicaid application process. These materials are to be provided in a simple and straightforward manner that can be understood by the average applicant and that meets all applicable civil rights requirements.

Upon further consideration of these public comments, we have decided to provide additional clarification and flexibility for States in meeting this requirement. We have added §§ 457.350(e)(4) and 457.350(g)(3) to reflect that the written format and timing of information regarding Medicaid eligibility, benefits, and the application process will be determined by the State. However, States will still be required to provide families with information about Medicaid eligibility, benefits, and the application process. The State must provide the information when the child is found potentially ineligible for Medicaid through a limited eligibility screening and when the child is found potentially eligible for Medicaid as described in § 457.350(e) and (g). These new revisions clarify that the required information may be in the form of handouts, brochures, or other written material provided during the application process. This approach may help to avoid lengthy, complex eligibility notices that are often confusing to families. As previously noted in the preamble, we are working to identify appropriate notice language and best practices and will disseminate this material to States (66 FR 2548). We note that, as discussed in detail below in section II.A.3. of this document, we have removed § 457.350(f)(5)(iii).

3. Presumptive Eligibility § 457.355

In the January 2001 final rule, we included § 457.355 regarding presumptive eligibility under a separate child health program as authorized under section 803 of BIPA. The BIPA had been enacted less than a month before the publication of the January 2001 final rule. The revisions to this section are technical changes to accurately reflect BIPA as we now understand it. These changes assure that the BIPA provision authorizing presumptive eligibility under a separate child health program is effectively and efficiently implemented.

Comment: We received one comment urging HCFA to include information about presumptive eligibility under a separate child health program in the preamble to the regulation that implemented the SCHIP financial provisions (65 FR 33616). Another urged HCFA to encourage States to provide presumptive eligibility for children as this is particularly important to children experiencing a mental health crisis (66 FR 2533).

Response: In our previous response, we stated that States were given explicit authority to implement a presumptive eligibility procedure under its separate child health program with the enactment of the Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554). Under section 803 of BIPA, States were given the option to establish a presumptive eligibility procedure and to determine which entities must determine presumptive eligibility, subject to the approval of the Secretary.

Under the presumptive eligibility established under Medicaid and carried over to SCHIP under the BIPA legislation, a family has until the end of the month following the month in which the presumptive eligibility determination is made to submit an application for the separate child health program (or the presumptive eligibility application may serve as the application for the separate child health program, at State option). If an application is filed, the presumptive eligibility period continues until the State makes a determination of eligibility under the separate child health program (subject to the Medicaid screening requirements). In accordance with § 457.355, if a child enrolled in a separate child health program on a presumptive basis is later determined to have been eligible for the separate child health program, the costs for that child during the presumptive eligibility period will be considered expenditures for child health assistance for targeted low-income children and subject to the enhanced FMAP. If the child is found to have been Medicaid-eligible during the period of presumptive eligibility, the costs for the child during the presumptive eligibility period can be considered Medicaid program expenditures, subject to the appropriate Medicaid FMAP (the enhanced match rate or the regular match rate, depending on whether the child is an optional targeted low-income child).

We further stated that BIPA authorizes presumptive eligibility under separate child health programs in accordance with section 1920A of the Act, and the statute allows health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children when the child is ultimately found not to be eligible for either the separate child health program or Medicaid, as long as the State implements presumptive eligibility in accordance with section 1920A and § 435.1101. This policy preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with § 435.1101 to no longer be constrained by the 10 percent cap.

Upon further consideration and analysis of BIPA, we are correcting our previous analysis with respect to expenditures for a child who is found to have been Medicaid-eligible during a period of presumptive eligibility. Our analysis now concludes that the title XXI enhanced FMAP rate is available for services provided to a child during a period of presumptive eligibility implemented in accordance with section 1920A and § 435.1102. Since Medicaid presumptive eligibility is paid at the FMAP rate generally available in Medicaid, we believe SCHIP presumptive eligibility should be paid at the rate generally available under Title XXI, the enhanced FMAP rate. The expenditures for this period of presumptive eligibility will be

considered child health assistance that is not subject to the 10 percent limit on outreach and health services initiatives, regardless of whether the child is ultimately determined eligible for the separate child health program, eligible for Medicaid, or ineligible for both programs. SCHIP presumptive eligibility is not one of the listed categories of expenditures limited by section 2105(c)(2)(A), as amended by BIPA. Accordingly, we have revised § 457.355, ''Expenditures for coverage during a period of presumptive eligibility'' to indicate that these expenditures will be considered as child health assistance when implemented in accordance with § 435.1102. States that adopt presumptive eligibility in both their separate child health program and Medicaid expansion program should presumptively enroll children into the appropriate program based on their family income under the highest applicable income standard for Medicaid or the separate child health program in order to avoid the need to move children between programs when a final eligibility determination is made.

Comment: Two commenters recommended that HCFA encourage States that have separate child health programs to provide newborn infants the same eligibility protections granted under Medicaid. Another recommended that HCFA allow pre-enrollment of newborns or automatic enrollment of newborns of pregnant teens enrolled in a separate child health program (66 FR 2541).

Response: We previously responded that the statute does not provide for automatic and continuous eligibility for infants under a separate child health program but suggested using ''presumptive eligibility'' to enroll children in a separate child health program pending completion of the application process as a means to address this issue. We stated that, if the infant is ultimately found not to be eligible for Medicaid, costs of services provided during the period of presumptive eligibility may be treated as health coverage for targeted low-income children that is not subject to the 10 percent cap. This would apply whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A of the Act and § 435.1101.

As a result of our review of the previous response and section 803 of BIPA, we clarify here that when a newborn is enrolled in a separate child health program pending a formal determination of eligibility for Medicaid or SCHIP, the costs for the presumptive eligibility period are considered child health assistance. These costs are not subject to the 10 percent cap on administration and health services initiatives, as long as presumptive eligibility is implemented in accordance with § 435.1102.

Comment: A few commenters indicated that the regulations should clarify that a child can be enrolled in a separate child health program while undertaking the full Medicaid application process. Other commenters recommended enrolling a child in a separate child health program for 45 days to allow processing of the Medicaid application (66 FR 2548).

Response: In our previous response to these comments, we stated that a State has the option to provisionally enroll or retain current enrollment of a child who has been found potentially eligible for Medicaid in a separate child health program, for a limited period of time, as specified by the State, pending a final eligibility decision. We stated, however, that a child cannot be ''eligible'' for the separate program unless a Medicaid application is completed and a determination made that the child is not eligible for Medicaid.

In that previous response, we indicated that BIPA permits health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and § 435.1101. We stated that, in that circumstance, the State would no longer be constrained by the 10 percent cap.

As a result of our review of the previous response and section 803 of BIPA, we clarify here that a child may be provisionally enrolled or retain current eligibility in a separate program, for a limited period of time, pending a final eligibility determination for Medicaid or SCHIP. When implementing presumptive eligibility consistent with § 435.1102, the presumptive eligibility period would begin on the date that a qualified entity determines that the child has family income below the applicable income level and end on the day a Medicaid or separate child health program eligibility determination is made, or, if an application is not filed, the last day of the month following the date presumptive eligibility began. The costs are considered child health assistance and are not subject to the 10 percent cap on administration and health services initiatives, as long as presumptive eligibility is implemented in accordance with § 435.1102.

Comment: Many commenters were concerned generally about families ''falling through the cracks'' because of the back and forth between separate child health programs and Medicaid or going without any health care for a period of time because of the process requirements. A significant number suggested that the regulation provide that a State cannot require a child to reapply for a separate child health program if the child is screened potentially eligible for Medicaid, but later determined ineligible for Medicaid. Most suggested that the separate child health program application should be suspended or provisionally denied when a child is found to be potentially eligible for Medicaid, pending a final Medicaid eligibility determination (66 FR 2549).

Response: We previously responded, in part, by clarifying § 457.350(f)(1) to indicate that a State may suspend, deny or provisionally deny the separate child health application of a child screened potentially eligible for Medicaid. Putting the application into suspense or provisionally denying an application would preserve the child's initial application date so prompt follow-up could occur when the State agency or contractor learns that the child has been determined ineligible for Medicaid. The child's initial application would then be reactivated. We indicated that the regulation at § 457.350(f)(5) requires that, if a child screened potentially eligible for Medicaid is ultimately determined not to be eligible for Medicaid, the child's original application for the separate child health program must be reopened or reactivated and his/her eligibility under the separate child health program determined without a new application. We also noted that a State could establish a presumptive eligibility process for a separate child health program to enroll an applicant in the separate child health program pending the formal determination of Medicaid eligibility.

After reviewing our previous response and section 803 of BIPA, we now provide further clarification that provisional denial or suspension of an application for a separate program would permit the child to be presumptively enrolled pending the outcome of a Medicaid eligibility determination. This presumptive eligibility period would be time limited. As indicated previously, when implementing presumptive eligibility consistent with § 435.1102, the

presumptive eligibility period would begin on the date that a qualified entity determines that the child has family income below the applicable income level and end on the day a Medicaid eligibility determination is made, or, if a Medicaid application is not filed, the last day of the month following the date presumptive eligibility began. However, if the application for the separate child health program is denied, then presumptive eligibility in the separate child health program would end.

In addition, we have decided to withdraw § 457.350(f)(5)(iii). While it is ordinarily advisable for States to reopen or reactivate the child's original application for the separate child health program following a denial of Medicaid eligibility, there may be circumstances in which a new application would be warranted. For example, considerable time may elapse following the initial application, for reasons beyond the State's control, and information on the initial application may no longer be valid. Therefore, while we strongly encourage States to reactivate the original application, we have removed § 457.350(f)(5)(iii) in order to allow State discretion in this matter.

B. Secretary-Approved Coverage (§ 457.450)

Section 457.450 of the January 2001 final rule provided examples of Secretary-approved coverage. After further review of the public comments, we are amending our prior responses and revising the final rule. This revision is intended to clarify that these examples were not meant to be exclusive. The revision also expands the list of examples to ensure that the regulation clearly reflects the breadth of possible Secretary-approved coverage.

Comment: One commenter argued that ''Secretary-approved coverage'' should provide HCFA with greater flexibility to approve SCHIP State plans. The commenter pointed out that Secretary-approved coverage is not simply another name for benchmark coverage; title XXI provides for Secretary-approved coverage as a flexible way for HCFA to approve a State plan. The statute requires no actuarial analysis for this option but rather requires only that the coverage be deemed ''appropriate'' for the targeted population.

The commenter recommended that the regulation should simply indicate that States must demonstrate, to the Secretary's satisfaction, that their coverage meets the needs of their SCHIP populations. The manner in which States make this demonstration should be left flexible in accordance with the discretion accorded to the States by title XXI (66 FR 2567).

Response: We previously responded to this comment by stating that the regulation text at § 457.450 was not meant to be an exhaustive list of examples of Secretary-approved coverage and that we remained open to reviewing other proposals for Secretary-approved coverage.

Upon further consideration of this comment; however, we are revising the regulation text to make our intent clear. We have added the phrase ''but is not limited to'' to clarify our intent to consider other benefit packages under Secretary-approved coverage. In addition, we have revised § 457.450(b) to permit comprehensive coverage for children under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act to be considered Secretary-approved coverage. At § 457.450(c), we permit coverage that includes the full benefit for early and periodic screening, diagnosis, and treatment or that the State has extended to the entire Medicaid population in the State to be considered Secretary-approved coverage. We have also added a new § 457.450(e) to clarify that States may offer coverage that is the same as that provided by Florida, New York and Pennsylvania under their existing comprehensive State-based coverage programs. These benefit packages were acknowledged in the original title XXI statute as providing appropriate coverage for children by permitting those States to continue using the same coverage under SCHIP. These modifications will support our consideration of a wider range of benefit packages and provide additional flexibility to States in proposing coverage that is appropriate for the target populations.

C. State Assurance of Access to Care and Procedures to Assure Quality and Appropriateness of Care (§ 457.495(d))

Section 457.495(d) of the January 2001 final rule provided that decisions related to the prior authorization of health services must be completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services. After further review of the comments, we are amending our prior responses and revising the final rule.

Comment: Several commenters recommended that HCFA identify time frames for decisions related to prior authorization of services to assure that individuals have access to services without unreasonable delay and that services are provided as expeditiously as an enrollee's health condition requires.

Response: In the January 2001 final rule, we responded that we agreed with the commenter's recommendations and provided time frames for decisions related to prior authorization of services. These time frame requirements provided that the decision must be completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services. We also allowed for a possible extension of up to 14 days if the enrollee requested the extension or the physician or health plan determined that additional information was needed.

Upon further consideration, we have decided to amend § 457.495(d) to allow States to use either the standards established in § 457.495(d) or their existing State law procedures regarding prior authorization. Allowing States to use their existing State laws will reduce the administrative burden of these regulations for States with premium assistance programs, as States usually do not have direct contractual relationships with employers group health plans. Given that most States already have systems in place to regulate private health plans, this change in policy will allow them to use those existing systems. Those States that do not have such systems in place must comply with the standards set forth in § 457.495(d).

D. Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

1. Computation of the Cumulative Cost-Sharing Maximum (§ 457.560(a))

Section 457.560(a) of the January 2001 final rule required States to count cost-sharing amounts that the family has a legal obligation to pay in computing whether the family has met the cumulative cost-sharing maximum. ''Legal obligation to pay'' is defined as amounts a provider actually charges the family for covered services, and any other amounts for which payment is required under applicable State law for covered services to eligible children, even if the family never pays those amounts. After further review of public comments and the applicable statutory requirement, we are revising these provisions to provide greater State flexibility in meeting the statutory requirements and in protecting beneficiaries.

Comment: A number of commenters disagreed with the proposed definition of ''legal obligation'' for use in connection with counting cost-sharing amounts against the cumulative cost-sharing maximum. They noted that it is

very difficult and time-consuming to track payments that have not occurred. One commenter suggested changing the definition of the term ''legal obligation'' to only those cost-sharing amounts, which families have actually paid (66 FR 2588).

Response: We previously responded that to track incurred costs, States could rely on documentation based upon provider bills that indicate the enrollee's share rather than relying only on evidence of payments made by the enrollee. We did not adopt the commenters' suggestion because it could result in families being legally obligated to pay cost-sharing amounts in excess of the cumulative maximum.

Upon further consideration of these comments, we are removing the definition of ''legal obligation to pay'' at § 457.560(a) because we have concluded that it does not ensure that enrollees' expenses are limited to the cost-sharing maximum in each year as intended. Requiring States to count incurred but not yet paid costs at the time that they are incurred could disadvantage some families, such as families that arrange payment plans. For these families, the payments made in a subsequent year would be counted in the year that they are incurred and not the year paid, which could result in the family paying an amount above the maximum in the subsequent year. Accordingly, we have eliminated § 457.560(a) in order to allow each State to define how it counts cost-sharing amounts against the cumulative cost-sharing maximum.

2. Children with Family Incomes at or Below 150 Percent of the FPL (§ 457.560(b))

Section 457.560(b) of the January 2001 final rule provided that for targeted low-income children with family income at or below 150 percent of the Federal poverty level (FPL), the State may not impose premiums, deductibles, copayments, coinsurance, enrollment fees, or similar cost-sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the length of the child's eligibility period in the State.

Comment: We received several comments requesting that we reconsider the 2.5 percent cumulative cost-sharing maximum. These commenters raised specific concerns regarding the 2.5 percent cumulative cost-sharing maximum, including the following: the provision is not supported by the statute; it is very difficult to administer two caps (2.5 percent and 5 percent) and track against two caps; limits on copayments and deductibles are already found in § 457.555 and section 2103(e)(3)(A) of the Act; States have already implemented flat cumulative cost-sharing maximums that are administratively efficient and provide families with fluctuating incomes greater stability; HCFA's commissioned study by George Washington University clearly demonstrates that it is rare that enrollees will reach the 5 percent cost-sharing maximum; and, when a limit is set using a percentage, there is no need to make the percentage less.

One of the commenters also noted that the Medicaid maximum charges for premiums and other cost-sharing charges, which apply to families at or below 150 percent of the FPL, are minimal in amount and are not based upon income or family size. As a result, the addition of another level of cost sharing (2.5 percent) adds to an already complex cost-sharing structure, in this commenter's view. The commenter added that the requirements are virtually impossible to implement in a program that subsidizes employer sponsored insurance (66 FR 2588).

Response: We previously responded that a lower cost-sharing maximum for children is necessary in order for States to comply with section 2103(e)(2)(B) of the Act, which requires that separate child health plans may only vary cost sharing based on the family income of targeted low-income children in a manner that does not favor children in families with higher incomes over children in families with lower incomes. We further explained that a State could ease administration by implementing a cost-sharing structure that places a 2.5 percent cap on families at all income levels or imposing premiums rather than copayments.

We have reconsidered our policy related to the cumulative cost-sharing maximum for families with incomes at or below 150 percent of the FPL. We acknowledge that lower income families have less disposable income to spend on health services than families with higher incomes. However, cost sharing for children at or below 150 percent of the FPL is limited to nominal amounts under the statute and final rule. Because of this limit on cost-sharing amounts for children in families at or below 150 percent of the FPL, it is unlikely any family in this income range would approach spending 5 percent of income on health services. The application of a 5 percent maximum to all income ranges is sufficient to ensure that children in higher income families are not favored over lower income families.

Therefore, we are revising the regulatory requirements at § 457.560 to limit cumulative cost sharing to 5 percent of family income for all children enrolled in SCHIP, regardless of family income. Section 457.560(b) has been removed and § 457.560(c), (now § 457.560(a)), has been revised accordingly. States may apply a lower cumulative cost-sharing maximum to children in lower income families or may place the same limit on children in families at all income levels, so long as the cost sharing maximum for eligible children does not exceed 5 percent of family income.

For the same reasons, we are revising our cost-sharing requirements that we would apply in evaluating a request for the purchase of family coverage, as discussed in the preamble of the January 11, 2001 final rule (66 FR 2622). Our previous policy required that cost sharing for the entire family, both adults and children, must remain within the cumulative cost-sharing maximum. Upon further consideration, we are revising this policy to require that only the cost sharing for the children in the family must be counted toward the cumulative cost-sharing maximum. Section 2103(e)(3)(B) specifies that cost sharing with respect to all targeted low-income children in the family may not exceed 5 percent of such family's income for the year. Therefore, States need not count an adult family member's cost sharing toward the cumulative cost-sharing maximum when providing family coverage.

E. Annual Report (§ 457.750)

Section 457.750 of the January 2001 final rule required States to submit an annual report to HCFA by January 1 of each year and specified the contents of that report. Specifically, § 457.750(b)(7) of the January 2001 final rule required that annual reports submitted by the State to include data on the primary language of SCHIP enrollees. Based upon further review of public comments, we are revising the final rule to delete this requirement.

Comment: We received several comments requesting that HCFA require States to collect data pertaining to one or more of the following categories of information about enrollees and their SCHIP coverage: gender, ethnicity, race, primary language, English proficiency, age, service delivery system, family income, and geographic location. Certain commenters suggested that these data be collected and reported to HCFA in the State evaluations, annual reports, and/or quarterly statistical reports. These commenters felt this information would help target outreach, retention, enrollment, and service efforts to under-represented groups. These commenters also indicated that such reporting requirements are consistent with the

goals of Healthy People 2010 and recently enacted legislation directing the Secretary of Commerce to produce statistically reliable annual State data on the number of uninsured, low-income children categorized by race, ethnicity, age, and income. One commenter indicated that HCFA should require States to document the appropriate range of services and networks of providers available, given the various language groups represented by enrollees. Additionally, some commenters noted that HCFA should require States to provide an assessment of their compliance with civil rights requirements.

Response: We previously agreed with several of the comments summarized above. Several commenters urged us to require States to report data on gender, race, ethnicity and primary language of SCHIP enrollees to HCFA. We included a provision in the January 11, 2001 rule to require States to report on primary language of enrollees in their annual report. We also included a provision in the January 11, 2001 rule to require States to report data, on a quarterly basis, on the race, ethnicity, and gender of SCHIP enrollees using the format prescribed by the OMB Statistical Directive 15—Standards for Maintaining, Collecting and Presenting Data on Race and Ethnicity. We felt that this policy was consistent with overall program goals, as well as the civil rights requirements.

Upon further consideration, we have decided to withdraw § 457.750 (b)(7) and will no longer require States to report primary language in their annual reports. States currently collect information on primary language in different ways (for example, on applications, through statewide surveys, etc.) In addition, States may find that collecting information about the primary language of the head of household rather than the child applicant/enrollee is more useful, for example, for purposes of translating written materials about the program. Therefore, we find that providing States with flexibility to decide what information to collect about primary language, and how to collect it, will best serve the needs of the program and that withdrawing this provision will not inhibit the Federal government from effectively evaluating the program. We have retained the requirement for States to report data on gender, race, and ethnicity at § 457.740(a)(3)(ii) and § 457.740(c).

After reviewing this subpart, we find that further revision is not necessary. Therefore, we have retained the other requirements for the contents of the annual report as stated in the January 11, 2001 final rule, including the requirement to provide information related to a core set of national performance measures as developed by the Secretary. We want to reiterate our statements from the January 11, 2001 final rule that we are mindful of the complexities of developing these measures and will work closely with States to do so. We plan to convene a workgroup with States to develop a limited set of core performance goals and measures. As we undertake this effort, we will be guided by the objectives, goals, and measurement methods States have already developed.

F. Program Integrity

1. Procurement Standards (§ 457.940)

Section 457.940(d) of the January 2001 final rule requires that all contracts under part 457 include provisions that define a sound and complete procurement contract, in accordance with the procurement requirements of 45 CFR part 74. We are making a technical change to accommodate a possible change in Departmental policy.

Comment: Several commenters recommended that procurement standards in 45 CFR part 92 are more appropriate for non-entitlement programs, such as SCHIP, because they allow States to use their own procurement standards when purchasing services with Federal grant money. Commenters stated that flexibility will enable States to make cost-effective and quality health plan selections. One commenter noted that flexibility to establish higher rates to ensure provider participation should be coupled with stricter enforcement (66 FR 2615).

Response: We disagreed with the commenter's recommendation for changing the procurement standards applicable to SCHIP. We stated that the procurement requirements of 45 CFR 74.43 are more appropriate for separate child health programs because they allow for accountability as well as State flexibility in implementation.

Upon further consideration, we have decided to revise our policy to allow States to use the procurement requirements of either 45 CFR 74.43 or 45 CFR 92.36, as applicable. Currently, the Department has issued a Notice of Proposed Rulemaking in the **Federal Register** published on November 15, 2000, to amend 45 CFR 92. When this regulation change is final, the applicable procurement requirement for SCHIP will be 45 CFR 92.36. Until this regulation change is final, the provisions of 45 CFR 74.43 are applicable to SCHIP.

2. Verification of Enrollment and Provider Services Received

Section 457.980(a) of the January 2001 final rule provided that the State must establish methodologies to verify whether beneficiaries have received services for which providers have billed. Based upon further review of public comments, we are removing § 457.980(a) because we do not believe that this provision is necessary to comply with applicable statutory requirements or effective and efficient program operation.

Comment: Several commenters noted that the provisions in § 457.980 could be difficult to implement in managed care plans and that verification may be burdensome in a capitated system. The commenters requested that we clarify that it would be acceptable if there were a provision in the contract with the health plan to ensure provider services. One commenter expressed concern regarding external verification of provider services received in the managed care market, especially in capitation-based plans. The commenter felt that States should be able to handle this through the normal provider evaluation and review procedures used by managed care entities (66 FR 2618).

Response: In our previous response to these comments, we indicated that it is necessary for the effective and efficient administration of any State separate child health insurance program to monitor and verify enrollee receipt of services for which providers have billed or received payment, or that providers have contracted to furnish regardless of the method of payment. Therefore, the provisions of § 457.980(a) apply to States using managed care plans as well as other systems of health insurance and care delivery. Plans participating in SCHIP are accountable to the State for providing services and care to SCHIP participants. States must ensure, when contracting with providers, that beneficiaries are receiving care they are entitled to and for which States have provided funds.

Upon further consideration, we have decided to remove § 457.980(a). This provision would be difficult to apply to managed care settings in which individual services are not billed to the State. States also have interpreted this provision as holding them responsible for the internal workings of the managed care plans. Although the fiscal integrity of payments made under SCHIP is important, when this provision is removed, the provision at § 457.980(b) is

adequate to address the need for program integrity.

G. Applicant and Enrollee Protections

We previously explained that subpart K—Applicant and Enrollee Protections—was developed to consolidate and clarify certain provisions involving applicant and enrollee protections. More specifically, the subpart defined the components of a review process and established minimum requirements. The subpart applied only to separate child health programs.

Our previous policy required States to adopt all of the minimum requirements in subpart K in designing their review process for their separate child health program. States contracting with providers that were subject to applicable State consumer protection law that met or exceeded the requirements in the regulation could rely upon State law to satisfy the review requirements. In the absence of State law, States were required to adopt a review process that met the requirements of this regulation.

While we will continue to strongly support the need for consumer protections for all SCHIP-eligible children, we have revised our previous policy to afford States greater flexibility in designing their review processes. Our new policy will require States to either meet the requirements of §§ 457.1130–457.1180 *or* to demonstrate that participating providers comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State. For example, if a State had a grievance and appeal law that applied to HMOs and the State provides coverage under SCHIP through managed care plans, then States would have the option of requiring the plans to meet the HMO review requirements under the State law. In absence of any State law governing grievance and appeals, a State is required to demonstrate compliance with Subpart K. We have revised § 457.1120 accordingly. Furthermore, we have revised §§ 457.1130, 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180 by adding ''Program Specific Review Process:'' at the beginning of each section heading to clarify that these provisions apply to a program specific review process as defined in § 457.1120(a)(1), and not to a Statewide standard review as defined in § 457.1120(a)(2).

The basis for this decision is explained in greater detail in the following summary of public comments received on the proposed regulation and published in the January 11, 2001 final rule.

Overview of Enrollee Rights

Comment: A number of commenters supported HCFA's efforts to incorporate the Consumer Bill of Rights and Responsibilities (CBRR) provisions in the proposed regulations (66 FR 2627). Another supported HCFA's effort to offer States a good deal of flexibility in the application of these requirements.

Other commenters believed that HCFA exceeded its statutory authority in applying the CBRR to SCHIP regulations. Commenters noted that the requirements could be in conflict with existing State law, severely limited States' flexibility in contracting, and hampered their ability to adjust contract provisions that are not working well. The commenters asserted that applying the CBRR to SCHIP could result in coverage for children in Medicaid expansion programs under consumer protections available in Medicaid, while children in separate child health programs would be covered under State consumer protection laws. One commenter suggested that, where a conflict existed, or State law imposed similar requirements, State law should prevail. Other commenters indicated that the requirements presented an administrative burden to the State.

Response: Upon further consideration, we have revised review requirements to permit greater State flexibility. While we will continue to expect States to have adequate consumer protections for SCHIP children, we will not require that a State's review process adhere explicitly to the requirements identified in this subpart. We believe that State law will generally provide adequate protections for enrollees, and the benefits of using existing processes rather than creating a separate process solely for SCHIP children will greatly enhance the ease with which States can administer their programs. As discussed earlier, our new policy will require States to either meet the requirements of §§ 457.1130–457.1180 *or* to demonstrate that participating providers comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State.

We recognize that the protection of enrollee rights is a critical component of program costs for the provision of child health assistance, and we have carefully balanced this concern against the administrative burden our requirements impose on the States. We believe that the revised requirements will address the commenter's concerns related to administrative burden, and we remain of the view that the costs of ensuring applicant and enrollee protections need not be large relative to the cost of services provided to enrollees. We believe that the revision of our previous policy affords States even broader flexibility to design and implement efficient and effective review processes.

Overview of Applicant and Enrollee Protections in Final Regulation

In the January 11, 2001 final rule, we discussed the protections for applicants and enrollees in separate child health programs that had been incorporated throughout the regulation (66 FR 2629). Given that we have revised our policy in this subpart and others, the following information updates references to this subpart and other subparts of the regulation:

- Review Process

Upon further consideration we have revised our requirements for a review process for health services matters. Previously, we defined minimum requirements in §§ 457.1130(b) and 457.1150(b) to provide enrollees in separate child health programs with an opportunity for an independent external review. Section 457.1160(b) set a standard and expedited time frame for reviews of health services matters.

We continue to expect that a State will have an independent, external review process for health services matters and that specific time frames be in place for such a review. However, we have revised our requirements to afford States greater flexibility in the design of such a review process. More specifically, rather than designing a new review process specifically for a separate child health program, States may choose to require providers to comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers as a means to comply with this regulation.

Review Processes

In the January 2001 final rule, we clarified that matters subject to review included eligibility and enrollment matters and health services matters. We further defined that an appropriate ''review process'' in a separate child health program would address the matters subject to review and would include the following components: core elements of review, impartial review, time frames, continuation of enrollment, and notice. Finally, we explained the applicability of the review process when States offer premium assistance for group health plans.

In the January 2001 final rule, we clarified that a State had to implement a review process that included all of the components and met all of the minimum requirements in each of these areas. We also indicated that existing State law that governed private health plans would only apply to the extent that the State law met or exceeded the minimum requirements.

Upon further consideration of the public comments, we have decided to revise our review requirements as described earlier and have articulated our rationale in the responses to the following summary of comments received on subpart K published in the **Federal Register** published January 11, 2001.

Comment: Commenters noted that the lack of minimum standards for review processes may cause lengthy time periods for completion of grievance and appeals processes, leaving many enrollees without needed benefits (66 FR 2633). The commenters recommended that HCFA establish a set of minimum standards that States and participating providers must meet when providing services to enrollees. Other commenters expressed their view that the rules lack sufficient clarity and specificity to ensure that consumers will be accorded adequate due process protections in a State that does not adopt the Medicaid procedures.

As discussed we also received a number of comments that HCFA exceeded its statutory authority under title XXI in defining specific requirements for a review process (66 FR 2633). Several commenters believed States should be allowed to use existing appeal mechanisms for managed care. One commenter noted opposition to Federal requirements that would force the States to alter standard commercial plan contracts (for example, specific appeals criteria or procedures), and urged HCFA to allow States to develop appeals and grievance procedures that are consistent with State insurance regulations. Other commenters argued that Federal requirements for resolving enrollee complaints and grievances would reduce plan participation because many plans would not be willing to have separate processes for SCHIP enrollees that exceed existing State statutory requirements.

Response: Upon further consideration, we have decided to revise our policy related to establishing minimum standards. We had previously indicated that in an effort to strike a balance between State flexibility and enrollee protection consistent with the provisions and framework of title XXI, subpart K had been developed to assure a minimum set of standards for all individuals obtaining services through SCHIP. However, in light of the fact that the majority of States have existing consumer protection laws that govern the private insurance market; concerns that providers may elect not to participate in SCHIP if they must assure additional (and possibly duplicative) protections for enrollees; and concerns related to the potential administrative burden associated with developing and implementing the protections identified in this regulation we have decided to provide additional flexibility to States in this area.

Therefore, the revised regulation provides States with the option of either designing a review process that meets the requirements of §§ 457.1130—457.1180 or demonstrating that participating providers comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State. States, with or without State law, may still elect to use the Medicaid fair hearing process to satisfy the requirements of this regulation, however it is not required.

Comment: Commenters recommended that HCFA further define matters that must be subject to review. Commenters also indicated that eligibility matters should be reviewed under separate processes than health services matters, and that the review process for eligibility determinations should be the Medicaid grievance and fair hearing process rather than deferring to internal appeals or State-specific insurance practices (66 FR 2637). Another noted that the external system of review should be as close as possible to that of Medicaid.

Response: We previously responded that matters subject to review would include eligibility and enrollment matters and health services matters. We agreed with the comment that internal and external review consistent with State insurance law may not be the appropriate form of review for eligibility and enrollment matters, but we left this matter to State discretion, as long as the minimum review requirements were met. We decided not to require that the external review for separate child health programs mirror the external review process required under Medicaid and to take a more flexible approach consistent with title XXI.

As discussed earlier, we have revised this regulation to allow States to either design a review process that meets the requirements of §§ 457.1130—457.1180 or to demonstrate that participating providers comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State. States that elect to use State-specific grievance and appeal requirements still must provide an opportunity for review of all the matters listed in § 457.1130. We recognize that State law may not use the same terminology as § 457.1130; however the State law must be consistent with the intent of § 457.1130 to comply with this regulation. States without law that is consistent with § 457.1130 will have to identify a method for providing an opportunity for review for those items not covered by the State legislation.

Comment: We received a number of comments on the proposed scope of the review process (66 FR 2639). The following summarizes the key issues raised by commenters related to several of the minimum requirements (excluding matters subject to review or the applicability of the review process to States with premium assistance programs, which are addressed in separate comments):

Core Elements of Review: Several commenters suggested that HCFA develop minimum standards for a review process to assure that all enrollees in SCHIP are afforded basic consumer protections. Other commenters asserted that the establishment of minimum standards created an additional administrative expense for States, particularly given that many separate child health programs involved entities that are already subject to existing State consumer protection law. One commenter stated their view that a choice between Medicaid and State insurance practices is appropriate for issues other than eligibility and disenrollment determinations. Another commenter expressed that HCFA's intent was not clear and that they were unsure whether States without existing State laws requiring internal and external review procedures must establish any procedures for children enrolled in SCHIP.

Impartial Review: Several commenters recommended that the State be involved in all external reviews to assure that an independent and impartial review occurs.

Timeframes: Several commenters noted that the regulation should require that grievances and appeals be decided in a timely fashion, and a number of commenters suggested appropriate timeframes. A different commenter, representing providers, noted that it saw no reason why providers should not be expected to respond within seven days

to a request for treatment. The commenter also believed that HCFA should establish minimum requirements for an expedited procedure to meet the needs of enrollees with severe medical conditions. Another commenter requested that HCFA clarify whether a State that has existing laws relating to consumer protections is able to choose its Medicaid procedures instead.

Notice: Several commenters expressed support for the inclusion of rules setting minimum standards for procedural fairness. One commenter noted that notice is a basic due process right required by the U.S. Constitution under well-settled law whenever a citizen is denied a public benefit, and that the rules should specify that notice must be timely. The commenter also recommended that for current recipients, notice of an adverse action should be in advance of the action. Another commenter recommended notice include information regarding the right to appeal and to be accompanied to the hearing by a representative.

Response: We previously responded by expressing appreciation for all commenters supporting our decision to develop minimum requirements for a review process and stated that we had the statutory authority to require States to adopt such requirements.

Because we believed that all SCHIP-eligible children should be afforded a minimum set of consumer protections regardless of the State within which they reside, we did not support suggestions to allow existing State law to apply. We argued that State laws applicable to commercial plans may or may not apply to a separate child health program, depending on the provisions of the State law. Additionally, we said that the scope of State law varies from State to State and enrollees would be subject to a different degree of protection depending upon where they enrolled in the program. We also indicated that we expected that States that decide to adopt Medicaid procedures for the review process in their separate child health program would thereby be meeting State law requirements applicable to commercial health plans.

We also addressed commenters' concerns that certain enrollee protections may create an additional administrative expense for some States by indicating that the importance of ensuring an enrollee's basic right to a fair and efficient decision regarding eligibility and enrollment or health services matters justified the administrative expenses that may be incurred.

Upon further consideration, we have decided to revise this regulatory provision. Additional research regarding State consumer protection law reveals that most States do have existing laws that govern the private insurance market and many SCHIP providers are subject to this law. We also recognize the valid concern that providers may elect not to participate in SCHIP if they must assure additional (and possibly duplicative) protections for enrollees; the potential confusion for enrollees who could be subject to a different review process than other commercial enrollees in the same health plan, and the concern related to the potential administrative burden associated with developing and implementing the protections identified in this regulation.

Therefore, the revised regulation provides States with the option of either designing a review process that meets the requirements of 457.1130—457.1180 or demonstrating that participating providers comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State. States—with or without State law—may still elect to use the Medicaid fair hearing process to satisfy the requirements of this regulation, however, it is not required.

Comment: Commenters noted the difficulty of applying the requirements of this subpart in States with a premium assistance program given that States do not directly contract with providers in this situation. Commenters expressed concern that no State could ever comply thus making a premium assistance model impossible to implement (66 FR 2644).

Response: We previously responded by acknowledging that States' SCHIP programs do not have direct authority over group health plans that may be providing coverage under premium assistance programs. At the same time, we noted that there is no basis for providing children fewer procedural protections because they may be enrolled in a premium assistance program under SCHIP. In order to balance these concerns, the regulations provided States flexibility so that they may offer premium assistance through plans that do not meet the review standards set out in these regulations, as long as families are not required to enroll their children in these plans. Under § 457.1190, we indicated that a State that has a premium assistance program through which it provides coverage under a group health plan that does not meet the requirements of §§ 457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180 must give applicants and enrollees the option to obtain health benefits coverage through its direct coverage plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

The revision of this regulation to allow States to either design a review process that complies with this subpart or to use State-specific grievance and appeal requirements currently in effect provides additional flexibility to States implementing premium assistance programs. In addition to the option discussed in our previous response, States may enroll eligible children in group health plans that provide procedures that comply with the state-specific review requirements for health insurance issuers in the State. If the health plan is not subject to either the program specific review or the Statewide standard review, then the State will need to notify the enrollee that the plan does not necessarily comply with review procedures and must give children in the family the option to obtain health benefits coverage through its direct coverage plan. We have revised § 457.1190 to reflect this new requirement.

H. Compliance Dates

In the ''Effective Dates'' section of the January 2001 final rule, we stated that to the extent contract changes are necessary, States will not be found out of compliance until the next contract cycle. By contract cycles, we mean the earlier of the date of the original period of the existing contract, or the date of any modification or extension of the contract (whether or not contemplated within the scope of the contract).

As mentioned on page 2490 of the **Federal Register** published on January 11, 2001, in establishing the effective date for the regulation, we made allowances for contract cycles. To the extent contract changes are necessary, States would not be found out of compliance until the next contract cycle. We previously defined ''contract cycle'' as the earlier of the date of the original period of the existing contract, or the date of any modification or extension of the contract (whether or not contemplated within the scope of the contract).

Upon further review, we note that the definition of ''contract cycle'' leaves open the possibility that compliance requirements could be based on an unrelated contract modification, such as an update in payment rates, regardless of whether the state had the authority or leverage to obtain the necessary contract changes. Therefore, we have amended

the definition of ''contract cycle'' to be the earlier of the date of the original period of the existing contract, or the date of any extension or modification that would change the term of the contract. This change will clarify our intent that states ensure compliance with this rule by no later than the end of the contract.

We also note that the previous definition did not allow for, to the extent legislative changes are necessary, states to not be found out of compliance until the conclusion of the next legislative cycle following the effective date of the rule. To the extent legislative changes are necessary, states will not be found out of compliance until the conclusion of the next legislative cycle following the effective date of the rule.

III. Technical Revisions and Clarifications

In this final rule, we have made the following technical revisions and clarifications to the January 11, 2001 final rule:

• In the final rule published on January 11, 2001, we inadvertently omitted one of the qualified entities that may perform presumptive eligibility for Medicaid. As a result we have made a technical correction to §§ 435.1101 and 436.1101, adding paragraph (5) to each of these sections. This technical change adds entities that are authorized under section 803 of BIPA to determine Medicaid or SCHIP eligibility as qualified entities for the purpose of performing presumptive eligibility for Medicaid. We have also made this same conforming change under § 457.301 under the definition of ''qualified entity''. These same entities may perform presumptive eligibility for a separate child health program. (*See* §§ 435.1101 and 436.1101)

• The definition for *State health benefits plan* was inadvertently omitted from the final rule published in January 2001. We define the term as follows: ''State health benefits plan means a plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State. The term does not include a plan in which the State provides no contribution toward the cost of coverage and in which no State employees participate, or a plan that provides coverage only for a specific type of care, such as dental or vision care.''

We revised the definition from the proposed rule in order to clarify that we would not consider a benefit plan with no State contribution toward the cost of coverage and in which no State employees participate as a State health benefits plan.

• We revised § 457.60(b)(2) to refer to the requirements regarding substitution of coverage set forth at §§ 457.805 and 457.810. We revised § 457.60(b)(7) and (b)(8) to remove cross-references to other sections of part 457 that have been removed or revised.

• In the final rule published on January 1, 2001, we used the terms ''enrollee'' and ''enrollees'' in section 457.505(d) and (e). We changed these terms to ''eligible child'' and ''eligible children'' to make clear that these provisions apply only to cost sharing imposed on the children in a family.

• In §§ 457.1000, 457.1005 and 457.1010, we removed the term ''waiver for'' from these sections in order to clarify that States need only obtain approval for an amendment to their existing State plan, and do not need to submit a section 1115 demonstration project or ''waiver'' in order to implement these sections.

IV. Summary of Revisions to the January 11, 2001 Final Rule

In this final rule we are adopting the provisions set forth in the January 11, 2001 final rule with the following substantive changes:

• Revise the requirement regarding use of social security numbers to provide that a State may not require any family member who is not requesting services to provide a social security number (including those family members whose income or resources might be used in making the child's eligibility determination). (*See* § 457.320(b)(4))

• Add an option to permit States to require any applicant seeking assistance under SCHIP to furnish a social security number. The regulation adds a cross-reference to the Medicaid regulations regarding the use of social security numbers, which would apply to States electing this option. (*See* § 457.340(b))

• Add a requirement for the State to determine the written format and timing of information regarding Medicaid eligibility, benefits, and the application process that must be given to SCHIP applicants. (*See* §§ 457.350 (e)(4) and (g)(3))

• Remove the provision that the State must not require the child to complete a new application for the separate child health program following a denial of Medicaid eligibility, but may require supplemental information to account for any changes in the child's circumstances that may affect eligibility. (*See* § 457.350 (f)(5)(iii))

• Revise § 457.355(b) to provide that expenditures for coverage during a period of presumptive eligibility implemented in accordance with § 435.1102 of this chapter will be considered as expenditures for child health assistance under the plan. (*See* § 457.355 (b))

• Revise the provisions regarding Secretary-approved coverage to permit comprehensive coverage for children under a Medicaid demonstration project under section 1115 of the Act to be considered Secretary-approved coverage. (*See* § 457.450(b))

• Add the requirement that States may offer coverage that is the same as that provided by Florida, New York, and Pennsylvania under their existing comprehensive State-based coverage programs. (*See* § 457.450(e))

• Revise § 457.495(d) to allow States to use either the standards established in § 457.495(d) or existing State law regarding prior authorization of health services.

• Remove § 457.560(a) regarding cost-sharing amounts that the family has a ''legal obligation to pay'' to allow each State to define how it counts cost-sharing amounts against the cumulative cost-sharing maximum.

• Revise § 457.560(b) to limit cumulative cost sharing to five percent of family income for all children enrolled in SCHIP, regardless of family income. We have also made a conforming change to revise the cross reference at § 457.540(f) to refer to § 457.560(a).

• Remove the requirement that States collect and provide data in the annual report regarding the primary language of SCHIP enrollees. (*See* § 457.750(b)(7))

• Revise the Procurement standards requirements to refer to part 92 or part 74 for defining a complete contract. (*See* § 457.940(b) and (d))

• Remove the requirement that the State must establish methodologies to verify whether beneficiaries have received services for which providers have billed, to allow State flexibility in establishing a program integrity system that identifies, reports, and verifies the accuracy of claims. (*See* § 457.980)

• Revise § 457.1120 to provide that the State must have either a program specific review process that meets the requirements of subpart K or a Statewide standard review process that complies with State review requirements currently in effect for health insurance issuers in the State.

• Amend §§ 457.1130, 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180, by adding ''Program Specific Review Process:''.

• Revise § 457.1190 to refer to ''a program specific review or a statewide standard review.''

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite prior public comment on proposed rules. A notice of proposed rulemaking includes a reference to legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. In this case, a notice of proposed rulemaking was published on November 8, 1999 and a final rule was published on January 11, 2001 in response to comments received on the proposed rule. The January 11, 2001 rule's effective date was delayed so that we could give further consideration to the comments we had already received on the proposed rule. Because, this final rule including the modifications made in this publication is the product of notice and comment procedure, there is no need to engage in a further notice of proposed rulemaking before adopting this rule.

While we have decided to afford the public an opportunity to comment on the changes in the January 11, 2001 rule made by this document, we are doing this in the interest of openness and public participation, rather than as a legal obligation. In any event, the Administrative Procedure Act provides a mechanism under which advance notice and comment procedure may be waived, if the agency finds that good cause exists to waive that procedure. Good cause exists if the agency determines that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and the agency incorporates a statement of the finding and its reasons in the rule issued.

While under the Administrative Procedure Act we do not believe we are required to engage in notice and comment procedure at this juncture, we believe that good cause would exist were it necessary for dispensing with notice and comment because expeditious publication of the final rule will afford states with the additional certainty of the options which they will have available to them in implementing SCHIP programs. These will facilitate their ability to provide needed health care coverage to increased numbers of currently uninsured children. Accordingly, we find that notice and comment procedure in this instance would be contrary to the public interest since that procedure would unnecessarily impede furnishing needed health care coverage to needy children.

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $25 million or less annually. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million.

This interim final rule merely revises certain policies set forth in the January 11, 2001 final rule, which includes implementing regulations for the SCHIP program. The provisions set forth in this interim final rule will not have an impact of $110 million or more annually. Neither is this rule expected to impose an unfunded mandate on States exceeding $110 million annually. Therefore, we have not prepared an analysis of cost and benefits as required by E.O. 12866 and the Unfunded Mandates Act for rules with significant economic impacts or that impose significant unfunded mandates on States. Also, we believe the changes being promulgated in this document will have very little direct impact on small entities as defined under the RFA or on small rural hospitals as defined under section 1102(b) of the Social Security Act. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. For a detailed discussion of the impact of the SCHIP program, refer to the January 11, 2001 final rule (66 FR 2659).

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has federalism implications. In the January 11, 2001 issuance, on pages 2662 and 2663 of the **Federal Register**, we described extensive agency activities that involved consultation with State and local officials on program issues that have directly resulted in policies in both the proposed and the final rules. These activities are ongoing and continue to inform the development of agency policies and procedures. The description of these activities set forth in the January issuance is still valid and the activities discussed have informed development of the revisions contained in this document. Indeed, these revisions are essential to address concerns raised by State and local officials and to minimize the burden on State and local governments.

VIII. Collection of Information Requirements

This rule does not impose any new information collection and record keeping requirements subject to the Paperwork Reduction Act of 1995 (PRA).

The information collection requirements in §§ 457.50, 457.60, 457.70, 457.350, 457.360, 457.361, 457.431, 457.440, 457.525, 457.740, 457.750, 457.760, 457.810, 457.940, 457.965, 457.985, 457.1005, 457.1015, and 457.1140 of the January 11, 2001 final rule (66 FR 2490), have been approved by OMB under OMB control number 0938–0841. We sought comments on these requirements in the November 8, 1999 proposed rule and in the January 11, 2001 final rule and have made no changes to the requirements in this interim final rule. For a detailed discussion of the paperwork burden imposed by these provisions, see the January 2001 final rule (66 FR 2663).

List of Subjects

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs—health, Medicaid, Reporting and record keeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 436

Aid to Families with Dependent Children, Grant programs—health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Children's Health Insurance Program, Reporting and record keeping requirements.

42 CFR chapter IV, amended at 66 FR 2490 January 11, 2001, is further amended as set forth below:

A. Part 435 is amended as follows:

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

1. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart L—Option for Coverage of Special Groups

2. In § 435.1101, republish the introductory text of the definition of ''Qualified entity'' and amend the definition as follows:

A. Redesignate paragraphs (8), (9), and (10) as paragraphs (9)(i), (9)(ii), and (9)(iii), respectively.

B. Redesignate paragraphs (5) through (7) as paragraphs (6) through (8).

C. Add a new paragraph (5).

D. Revise newly redesignated paragraph (9).

E. Redesignate paragraph (11) as paragraph (10).

The addition and revision read as follows:

§ 435.1101 Definitions related to presumptive eligibility for children.

* * * * *

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

* * * * *

(5) Is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the State Children's Health Insurance Program;

* * * * *

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(ii) Is a State or Tribal office or entity involved in enrollment in the program under title XIX, Part A of title IV, or title XXI; or

(iii) Determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); and

* * * * *

B. Part 436 is amended as follows:

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

1. The authority citation for part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart L—Option for Coverage of Special Groups

2. In § 436.1101, republish the introductory text of the definition of ''Qualified entity'' and amend the definition as follows:

A. Redesignate paragraphs (8), (9), and (10) as paragraphs (9)(i), (9)(ii) and (9)(iii), respectively.

B. Redesignate paragraphs (5) through (7) as paragraphs (6) through (8), respectively.

C. Add a new paragraph (5).

D. Revise newly redesignated paragraph (9).

E. Redesignate paragraph (11) as paragraph (10).

The addition and revision read as follows:

§ 436.1101 Definitions related to presumptive eligibility for children.

* * * * *

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

* * * * *

(5) Is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the State Children's Health Insurance Program;

* * * * *

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(ii) Is a State or Tribal office or entity involved in enrollment in the program under this title, Part A of title IV, or title XXI; or

(iii) Determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); and

* * * * *

C. Part 457 is amended as follows:

PART 457—ALLOTMENTS AND GRANTS TO STATES

1. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

§ 457.60 [Amended]

2. Amend § 457.60 as follows:

A. Revise paragraph (b)(2).

B. In paragraph (b)(7) remove ''and 457.353''.

C. In paragraph (b)(8) remove ''§§ 457.1130, 457.1160, 457.1170, 457.1180 and 457.1190'' and add in its place ''§ 457.1120''.

§ 457.60 Amendments.

* * * * *

(b) * * *

(2) Procedures to prevent substitution of private coverage as described in § 457.805, and in § 457.810 for premium assistance programs.

* * * * *

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

§ 457.301 [Amended]

3. Amend § 457.301 as follows:

A. Republish the introductory text of the definition of ''Qualified entity'' and amend the definition as follows:

i. Redesignate the definition in alphabetical order.

ii. Redesignate paragraphs (8), (9), and (10) as paragraphs (9)(i), (9)(ii), and (9)(iii), respectively.

iii. Redesignate paragraphs (5) through (7) as paragraphs (6) through (8), respectively.

iv. Add a new paragraph (5).

v. Revise newly redesignated paragraph (9).

vi. Redesignate paragraph (11) as paragraph (10).

B. Add a definition of ''State health benefits plan,'' in alphabetical order.

The addition and revision read as follows:

§ 457.301 Definitions and use of terms.

* * * * *

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

* * * * *

(5) Is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the State Children's Health Insurance Program;

* * * * *

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(ii) Is a State or Tribal office or entity involved in enrollment in the program under this title, Part A of title IV, or title XXI; or

(iii) Determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.); and

* * * * *

State health benefits plan means a health insurance coverage plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State. The term does not include a plan in which the State provides no contribution toward the cost of coverage and in which no State employees participate, or a plan that provides coverage only for a specific type of care, such as dental or vision care.

* * * * *

4. Amend § 457.320 by revising paragraph (b)(4) to read as follows:

§ 457.320 Other eligibility standards.

* * * * *

(b) * * *

(4) Require any family member who is not requesting services to provide a social security number (including those family members whose income or resources might be used in making the child's eligibility determination);

* * * * *

§ 457.340 [Amended]

5. Amend § 457.340 by redesignating paragraphs (b) through (e) as (c) through (f) and adding a new paragraph (b) to read as follows:

§ 457.340 Application for and enrollment in a separate child health program.

* * * * *

(b) *Use of social security number.* A State may require a social security number for each individual requesting services consistent with the requirements at § 435.910(b), (e), (f), and (g) of this chapter.

* * * * *

§ 457.350 [Amended]

6. Amend § 457.350 as follows:

A. Add paragraphs (e)(4) and (g)(3).

B. Remove paragraph (f)(5)(iii).

The additions read as follows:

§ 457.350 Eligibility screening and facilitation of Medicaid enrollment.

* * * * *

(e) * * *

(4) The State will determine the written format and timing of the information regarding Medicaid eligibility, benefits, and the application process required under this paragraph (e).

* * * * *

(g) * * *

(3) The State will determine the written format and timing of the information regarding Medicaid eligibility, benefits, and the application process required under this paragraph (g).

* * * * *

§ 457.355 [Amended]

7. Amend § 457.355 as follows:

A. Redesignate paragraph (a) as paragraph (b).

B. Add paragraph designation (a) and paragraph heading to the introductory text.

C. Revise newly redesignated paragraph (b).

The revisions read as follows:

§ 457.355 Presumptive eligibility.

(a) *General rule.* * * *

(b) *Expenditures for coverage during a period of presumptive eligibility.* Expenditures for coverage during a period of presumptive eligibility implemented in accordance with § 435.1102 of this chapter may be considered as expenditures for child health assistance under the plan.

Subpart D—State Plan Requirements: Coverage and Benefits

8. Revise § 457.450 to read as follows:

§ 457.450 Secretary-approved coverage.

Secretary-approved coverage is health benefits coverage that, in the determination of the Secretary, provides appropriate coverage for the population of targeted low-income children covered under the program. Secretary-approved coverage, for which no actuarial analysis is required, may include, but is not limited to the following:

(a) Coverage that is the same as the coverage provided to children under the Medicaid State plan.

(b) Comprehensive coverage for children offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act.

(c) Coverage that either includes the full Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit or that the State has extended to the entire Medicaid population in the State.

(d) Coverage that includes benchmark health benefits coverage, as specified in § 457.420, plus any additional coverage.

(e) Coverage that is the same as the coverage provided under § 457.440.

(f) Coverage, including coverage under a group health plan purchased by the State, that the State demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan, as specified in § 457.420, through use of a benefit-by-benefit

comparison which demonstrates that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan.

9. Revise § 457.495(d) to read as follows:

§ 457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

* * * * *

(d) That decisions related to the prior authorization of health services are completed as follows:

(1) In accordance with the medical needs of the patient, within 14 days after receipt of a request for services. A possible extension of up to 14 days may be permitted if the enrollee requests the extension or if the physician or health plan determines that additional information is needed; or

(2) In accordance with existing State law regarding prior authorization of health services.

Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

§ 457.505 [Amended]

10. Amend § 457.505 as follows:

A. In paragraph (d)(1) remove ''enrollees'' and add ''eligible children'' in its place.

B. In paragraph (d)(3) remove ''enrollees'' and add ''eligible children'' in its place.

C. In paragraph (e) remove ''by an enrollee'' and add ''on behalf of an eligible child'' in its place.

§ 457.540 [Amended]

11. Amend § 457.540(f) by removing ''§ 457.560(b)'' and adding ''§ 457.560(a)'' in its place.

§ 457.560 [Amended]

12. Amend § 457.560 as follows:

A. Remove paragraphs (a) and (b).

B. Redesignate paragraphs (c) and (d) as paragraphs (a) and (b).

C. Revise newly redesignated paragraph (a) to read as follows:

§ 457.560 Cumulative cost-sharing maximum.

(a) A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State.

* * * * *

Subpart G—Strategic Planning, Reporting, and Evaluation

§ 457.750 [Amended]

13. In § 457.750 remove paragraph (b)(7) and redesignate paragraph (b)(8) as (b)(7).

Subpart I—Program Integrity

§ 457.940 [Amended]

14. Amend § 457.940 as follows:

A. In paragraph (b)(1), remove ''45 CFR 74.43'' and add in its place ''45 CFR 74.43 or 45 CFR 92.36, as applicable''.

B. In paragraph (d) remove ''45 CFR part 74'' and add in its place ''45 CFR part 74 or 45 CFR part 92, as applicable''.

§ 457.980 [Amended]

15. Amend § 457.980 as follows:

A. Remove paragraph (a); and

B. Remove paragraph designation (b).

Subpart J—Allowable Waivers: General Provisions

§ 457.1000 [Amended]

16. Amend § 457.1000 as follows:

A. In paragraph (a)(1) remove the phrase ''for a waiver''.

B. In paragraph (a)(2) remove the phrase ''a waiver for''.

§ 457.1005 [Amended]

17. Amend § 457.1005 by removing ''Waiver for'' from the section heading.

§ 457.1010 [Amended]

18. Amend § 457.1010 by removing ''Waiver for'' from the section heading.

Subpart K—State Plan Requirements: Applicant and Enrollee Protections

19. Section 457.1120 is revised to read as follows:

§ 457.1120 State plan requirement: Description of review process.

(a) The State must have one of the following review processes:

(1) *Program specific review.* A process that meets the requirements of §§ 457.1130, 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180; or

(2) *Statewide Standard Review.* A process that complies with State review requirements currently in effect for all health insurance issuers (as defined in section 2791 of the Public Health Service Act) in the State.

(b) The State plan must include a description of the State's review process.

§§ 457.1130, 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180 [Amended]

20. Amend §§ 457.1130, 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180 by adding ''Program specific review process:'' at the beginning of each section heading.

§ 457.1190 [Amended]

21. In § 457.1190, remove ''§§ 457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180'' and add ''a program specific review or a Statewide standard review, as described in § 457.1120,'' in its place.

(Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Health Insurance Program)

Dated: June 18, 2001.

Thomas A. Scully,

Administrator, Health Care Financing Administration.

Approved: June 20, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–15910 Filed 6–22–01; 8:45 am]

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